

## SYSTEMS REVIEW

Have you had any new medical conditions or health issues since your last physical? \_\_\_\_\_

Have any of your family members had any of the following diagnosed since your last physical?

- Diabetes                       Cancer of the breast/colon/prostate/ovaries/skin                       Aneurysm  
 Heart Attack before age 65                       Depression

**GENERAL** – Have you noticed:

- Significant weight change ( > 10#) in the past 6 months? If yes,  Increase     Decrease  
Significant recent appetite change? If yes,  Increase     Decrease  
Significant sweating or night sweats?     Yes     No

**SKIN** – Have you had:

- Recent rashes, lumps, or other skin / hair / nail problems?  Yes     No  
A history of skin cancer?  Yes     No

**EYES** – Have you had:

- Recent vision changes?  Yes     No    Last eye appointment: \_\_\_\_\_ With whom? \_\_\_\_\_  
Glaucoma/Cataracts?     Yes     No

**EARS / NOSE / MOUTH / THROAT** – Have you had:

- Hearing Problems?                       Yes     No; Do you have / use hearing aides?  Yes     No  
Frequent wax impaction?                       Yes     No  
Frequent nosebleeds?                       Yes     No  
Do you have a history of Obstructive Sleep Apnea?  Yes     No    If yes, do you use CPAP? \_\_\_\_\_  
Do you snore so loudly that your bed partner complains about it?  Yes     No  
Do you have excessive daytime fatigue?                       Yes     No  
Do you notice SIGNIFICANT dizziness, vertigo?                       Yes     No

## CARDIOVASCULAR

Do you get:

- Chest pain / pressure / tightness / squeezing?                       Yes     No  
If yes, does it occur with activity or exertion?                       Yes     No

– Please continue on reverse side –

SYSTEMS REVIEW

## SYSTEMS REVIEW (Page 2)

- Heart fluttering / flip-flops / skipping or palpations?  Yes  No
- Swelling of ankles?  Yes  No
- Pain in legs while walking?  Yes  No
- How far can you walk before you get short of breath?  Feet  Blocks  Miles  Unlimited
- Do you take antibiotics before dental work?  Yes  No
- Do you exercise on a regular basis (more than 2x per week)?  Yes  No
- If yes, what type of exercise? \_\_\_\_\_ How often? \_\_\_\_\_

### RESPIRATORY – Have you ever been told that you have:

- Asthma?  Yes  No
- Emphysema/chronic bronchitis?  Yes  No
- Blood clots in your leg or lung?  Yes  No
- Tuberculosis (TB) or positive TB skin test?  Yes  No
- Do you notice **frequent**:
- Wheezing / Shortness of breath?  Yes  No
- Coughing / Phlegm production?  Yes  No
- Coughing up blood?  Yes  No

### GASTROINTESTINAL – Do you notice:

- Frequent nausea or vomiting?  Yes  No
- Frequent diarrhea?  Yes  No
- Significant constipation?  Yes  No
- Bloody or black bowel movements?  Yes  No
- Frequent heartburn / regurgitation / indigestion?  Yes  No
- Do you take antacids or acid blocking agents more than once/week?  Yes  No
- Trouble swallowing / Food getting stuck?  Yes  No

Have you ever been diagnosed with:  Ulcers  Hepatitis  Colitis

**Have you ever had a colonoscopy?**  Yes  No

If yes, when \_\_\_\_\_

### GENITOURINARY – Do you notice:

- Burning / frequency or hesitation with urination?  Yes  No
- Do you wake up more than 2 times /night to urinate?  Yes  No
- Do you have significant difficulty starting your urine stream?  Yes  No
- Dribbling after urination or problems holding your urine?  Yes  No
- Do you have to wear a pad for incontinence more than once/week?  Yes  No
- Have you ever had kidney stones?  Yes  No
- If yes, when was your last episode? \_\_\_\_\_

## SYSTEMS REVIEW (Page 3)

Problems with your sex drive?  Yes  No

Have you ever had a sexually transmitted disease?  Yes  No

If yes, what type(s)?  Syphilis  Gonorrhea  Chlamydia  Warts

Are you sexually active  Yes  No; If yes, with:  Women?  Men?  Both?

How many sexual partners have you had in the last 6 months? \_\_\_\_\_

What kind of birth control do you use?  Condoms  Pills  IUD  Diaphragm

Tubal ligation  Vasectomy  None  Other \_\_\_\_\_

Do you use condoms?  Always  Most of the time  Rarely  Never

Have you ever been physically or sexually abused?  Yes  No

Would you like to discuss this further?  Yes  No

Do you feel safe in your current home/environment?  Yes  No

### WOMEN: – Do you have or have you had:

Problems related to menopause/change of life?  Yes  No

An abnormal Pap smear?  Yes  No; If yes, when \_\_\_\_\_

An abnormal mammogram?  Yes  No; If yes, when \_\_\_\_\_

Breast discharge, masses, or cancer?  Yes  No

### MEN:

Do you have difficulty with erections?  Yes  No

Would you like to discuss this further?  Yes  No

### MUSCULOSKELETAL – Do you have or have you had:

Significant joint pains or arthritis?  Yes  No If yes, which joints bother you most? \_\_\_\_\_

Gout?  Yes  No; If yes, last episode \_\_\_\_\_

Significant neck pain that bothers you most days?  Yes  No

Significant low back pain that bothers you most days?  Yes  No

### NEUROLOGICAL – Do you have or have you had:

Tremors / shakes?  Yes  No

Significant memory problems?  Yes  No

If yes, does it interfere with functioning?  Yes  No

A significant fall in the past year?  Yes  No

Seizures?  Yes  No

Significant headaches – severe enough to make you go home from school or work?  Yes  No

Blackouts / fainting spells?  Yes  No

If yes, when was your last fainting spell? \_\_\_\_\_

## SYSTEMS REVIEW (Page 4)

Significant numbness / tingling noted on a daily basis?  Yes  No

If yes, where is the numbness/tingling noted? \_\_\_\_\_

### MENTAL / EMOTIONAL

In the last 2 weeks, have you felt down, depressed, or hopeless?  Yes  No

Have you recently had little interest or pleasure in doing your day to day activities?  Yes  No

Have you ever had depression so severe that you considered suicide?  Yes  No

Do you feel that you worry excessively to the point where you feel your muscles tighten and/or can't sleep?  Yes  No

**Do you drink alcohol?**  Not at all  Occasionally  Daily

If you drink alcohol, on any single occasion in the past 3 months have you had more than 5 drinks containing alcohol?  Yes  No

**If yes:** On how many days per week do you drink alcohol? \_\_\_\_\_

On a typical day when you drink, how many drinks do you have? \_\_\_\_\_

What is the maximum number of drinks that you had on any given day in the past month? \_\_\_\_\_

Have you seen a psychiatrist or therapist in the past?  Yes  No

When were you last seen? \_\_\_\_\_ By whom \_\_\_\_\_

### HEMATOLOGIC / LYMPHATIC & ALLERGIC / IMMUNOLOGIC – Have you had:

Anemia?  Yes  No

Problems with your spleen or had your spleen removed?  Yes  No

Bleeding or clotting problems?  Yes  No

Easy bruising?  Yes  No

Do you have:

Seasonal allergies/hay fever?  Yes  No

If yes, do you take something for this? \_\_\_\_\_

Food, latex or drug allergies?  Yes  No

If yes, from what food and/or drug with what type of reaction? \_\_\_\_\_

Have you ever seen an allergist  Yes  No

### SOCIAL:

• Do you have a Durable Power of Attorney (DPA) for Health Care, Living Will or other Advanced Directives?  Yes  No

Would you like information regarding this?  Yes  No

• Do you have any other questions or would you like any information about a specific health related topic?

\_\_\_\_\_  
\_\_\_\_\_

*Thank you for taking the time to complete this questionnaire. It helps us provide the best possible health care for you.*